

FORM B: EPI-PEN OR INHALER USE & POSSESSION FORM
(not for over the counter medications)

Student's Name _____ Grade _____ School Year _____

PLEASE READ THE FOLLOWING OPTIONS AND MARK THE APPROPRIATE BOX BELOW.
SELECT OPTION 1, OPTION 2, or BOTH (if applicable):

OPTION 1

The medication is kept in the school health room. The student comes to the health room whenever medication is needed. The advantage to this option is that the use of the medication will be supervised and records will be kept as to the frequency of use. All medications brought to school must be in their original container with a current prescription label attached. In addition, the prescribing doctor must sign the applicable 'Asthma Care Plan' or 'FORM A: Allergy Action Plan and Emergency Care Plan'.

OPTION 2

The student carries the medication and uses it as prescribed. The student must have a doctor's permission noted in either the 'Asthma Action Plan' or 'FORM A: Allergy Action Plan and Emergency Care Plan' to use this option. The advantage of this option is that the medication is immediately accessible. It is recommended that extra medication be kept in the health room. Students who carry medications at school are expected sign the agreement below.

Student Agreement:

- I have been trained in the use of my auto injector and/or inhaler and understand the signs and symptoms when to use my prescription.
- I will notify a responsible adult (teacher, nurse, coach, etc.) **IMMEDIATELY** when an auto-injector (epinephrine) is used.
- I will go to the health room if there is no improvement in my symptoms.
- I will not share my medications with other students.

Student Signature _____ Date: _____

Please note the location of where your child is planning to carry the noted medication, such as their backpack, purse, or pockets: _____

I choose: **Option 1** as described above for my child.

Option 2 as described above for my child.

Parent/Guardian Signature _____ Date _____

I give permission for my child to use the medication described below at school.
Staff members can be informed about my child's condition in order for my child to receive appropriate care.

Name of Medication	Dose	Frequency